BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

WARREN YOUNG	)	
Claimant	)	
V.	)	
	)	
MIDWAY WHOLESALE	)	Docket No. 1,067,022
Respondent	)	
AND	)	
	)	
CINCINNATI CASUALTY COMPANY	)	
Insurance Carrier	)	

ORDER

Claimant, through John J. Bryan, requests review of Administrative Law Judge Rebecca A. Sanders' June 22, 2015 Award. Christopher J. McCurdy appeared for respondent and insurance carrier (respondent). The Board heard oral argument on December 8, 2015.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the Award's stipulations. At oral argument, the parties agreed the Board may consult and cite the AMA *Guides*[1] (hereinafter *Guides*) in rendering a decision.

ISSUES

Claimant injured his left knee on March 27, 2013. The judge awarded claimant a 7% functional impairment to the left leg based on the rating of Dr. Bieri, the court-ordered physician. The judge denied future medical treatment.

Claimant requests the Award be modified, arguing he sustained a 15% functional impairment to the left leg based on Dr. Prostic's rating. Claimant asserts only Dr. Prostic's rating accounts for his partial meniscectomy, atrophy and patellofemoral instability. Claimant also argues the judge erred in denying future medical treatment. Claimant asserts Dr. Prostic's testimony regarding future medical treatment is uncontradicted and sufficiently overcomes the presumption in K.S.A. 2012 Supp. 44-510h(e).

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[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted. The parties cannot cite the *Guides* without the *Guides* having been placed into evidence. See *Durham v. Cessna Aircraft Co.*, 24 Kan. App. 2d 334, 334-35, 945 P.2d 8, *rev. denied* 263 Kan. 885 (1997). The Board has ruled against exploring and discussing the *Guides*, other than using the Combined Values Chart, unless the relevant sections of the *Guides* were placed into evidence. See, e.g., *Billionis v. Superior Industries*, No. 1,037,974, 2011 WL 4961951 (Kan. WCAB Sep. 15, 2011).

Respondent maintains the Award should be affirmed. Respondent argues the judge was correct to award compensation based upon the rating of the court appointed physician. Respondent also argues the only future medical treatment recommended for the March 27, 2013 accident was a home exercise program because all other opinions regarding future medical, including injections and a total knee replacement, are speculative and relate to claimant's weight and preexisting degenerative conditions.

The issues are:

1. What is the nature and extent of claimant's disability?

2. Is claimant entitled to future medical treatment?

FINDINGS OF FACT

On March 27, 2013, claimant injured his left knee when his left foot slid on the edge of a truck step. A tow guard caught the front part of his left foot, twisting it clockwise. He felt a pop in his left knee. He fell about four feet to the ground, landing on his right leg. As his left leg came down, it turned the opposite direction of his right leg and he felt another jolt to his left knee. Claimant experienced immediate pain in his left knee.

Claimant was initially treated at Stormont-Vail Work Care and then referred to Benedict Figuerres, M.D., an orthopedic surgeon who is board eligible, but not yet board certified in orthopedics. Dr. Figuerres diagnosed claimant with a left medial meniscus tear. On June 3, 2013, Dr. Figuerres performed a medial meniscectomy and chondroplasty of the trochlea and patella. Dr. Figuerres found degenerative changes of the trochlea and medial facet of the patella. One-third of claimant's medial meniscus was removed. Dr. Figuerres provided medical treatment for degenerative changes by way of chondroplasty of the patella and femur. It was Dr. Figuerres' opinion the patellofemoral joint demonstrated grade III changes which he did not believe were caused by claimant's accident.[2]

Following surgery, claimant had 11 physical therapy sessions between June 19 and July 12, 2013. Initially, he reported difficulty walking, climbing stairs, sitting without his leg elevated, bending his knee and standing for prolonged periods of time. By July 8, 2013, claimant stated he was feeling 75% better. He reported improvement in his strength, range of motion, ability to walk and climb stairs.

On July 12, 2013, claimant returned to Dr. Figuerres and reported improvement, except for occasional pain with negotiating stairs. Dr. Figuerres noted claimant had full active range of motion. Claimant was released to work without restrictions.

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[2] See Figuerres Depo. at 11.

Dr. Figuerres last saw claimant on August 28, 2013. Claimant reported feeling much better, but complained of pain when changing direction. Dr. Figuerres noted claimant had full active range of motion of his left knee (-5° to 140°) based on visual inspection and without using a measuring device. Claimant had no effusion and claimant's motor and sensory examination was grossly intact without deficits. Dr. Figuerres released claimant to return to work with no permanent restrictions, but noted claimant could return to him on an as needed basis. Dr. Figuerres assigned a 0% impairment using only the range of motion chart in the *Guides*. He did not measure the circumferences of claimant's thighs or calves. In explaining his 0% rating, Dr Figuerres testified:

> A. According to the Guides, the Guides instruct me to assess range of motion as well as strength; and according to that, the Guides suggest that he has zero percent impairment.
>
> Q. When you saw Mr. Young on August 28, 2013, did you test his range of motion?
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> A. Yes, I did.
>
> Q. And what was his range of motion at that time?
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> A. Negative five to 140 degrees.
>
> Q. And is that full normal?
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> A. That is full range of motion.
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> Q. Okay. Doctor, the judge might have some questions on a patient who has an injury which has to be surgically repaired, but then results in zero percent permanent impairment. And, I guess, to kind of address that anticipated question, can you explain - - how do I ask this.
>
> Can you explain how the surgery plays into the equation in rating permanent impairment in your opinion, if it plays in it at all? Is it a factor that you consider?
>
> A. No. I factor in functional ability of the affected extremity which may be effected by surgery, but it doesn't play into my ultimate rating.
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> Q. So, let me ask it this way, the mere fact that this guy has a rating - - I'm sorry - - has surgery doesn't necessarily mean in your opinion that he had permanent impairment. What you're looking at is how does he recover from - - ultimately from that surgery; is that a fair statement?
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> A. That is a fair statement.[3]

[3] *Id*. at 14-16.

It was Dr. Figuerres' opinion claimant will not need a total knee replacement as a result of his work-related accident. Dr. Figuerres testified knee degenerative arthritis, trauma, surgery, weight and genetics can all be factors in causing the need for a total knee replacement. Dr. Figuerres testified claimant's surgery could accelerate claimant's preexisting degenerative arthritis.

In describing how removal of meniscus may affect the need for a total knee replacement in the future, Dr. Figuerres testified:

> Q. Okay. In talking with other doctors at different times about - - and Chris asked you questions similar along these same lines, how does a medial meniscus repair or medial meniscus tear which is repaired, what does that - - how does that predict or not predict the need for a total knee 20, 30 years down the road?
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> A. It depends on how much of the meniscus was taken out. If you took out the whole meniscus you would undoubtedly cause degenerative changes to develop within a short amount of time depending on activity level.
>
> Q. What about - - how much would - - how much would a third of it affect over 20, 25, 30 years?
>
> A. That's tough to say. I would not surmise it to necessitate a total knee.[4]

Dr. Figuerres also testified it would be "speculative" to predict whether the potential cause of claimant perhaps needing a total knee replacement 30 years down the road would be on account of his meniscal surgery.[5] Further, Dr. Figuerres stated he could not relate claimant's injury, which involved the medial compartment of his knee, as resulting in the need for a total knee replacement involving the patellofemoral compartment of claimant's knee, where he identified degenerative changes.

On February 4, 2014, at his attorney's request, claimant saw Edward Prostic, M.D., a board certified orthopedic surgeon. Claimant complained of frequent pain in the front of his left knee which worsened with progressive standing or walking, feeling uncomfortable upon awakening, difficulty with stairs, squatting and kneeling, continued clicking and popping, and an occasional giving way but no locking or sensitivity to inclement weather. Dr. Prostic testified some of these complaints demonstrate continuing patellofemoral dysfunction, arthritis and partial loss of the medial meniscus. Dr. Prostic indicated the difference in circumference of the left thigh compared to the right usually indicates quadriceps atrophy.

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[4] *Id*. at 28-29.

[5] *Id*. at 46-47.

Dr. Prostic's physical examination revealed, among other findings, satisfactory alignment, an external squint to the patella,[6] left thigh atrophy of one-half inch compared to the right thigh, and no significant tenderness or effusion. Claimant had patellar instability. Claimant's passive range of motion was measured to be 0° to 115°[7] with a patellar pop at 30° of flexion. The doctor suspected claimant's range of motion deficit was due to early fibrosis or inhibited by pain. Dr. Prostic recommended claimant continue with quadriceps strengthening exercises.

Dr. Prostic diagnosed claimant with grade III chondromalacia of the trochlea and medial patella, which is a significant wear injury, or significant depth of penetration, of articular cartilage. He noted claimant's knee surgery involved shaving of loose cartilage.

On March 3, 2014, Dr. Prostic assigned claimant a 15% permanent partial impairment to the left lower extremity pursuant to the *Guides*. Dr. Prostic assigned 2% for the partial meniscectomy, 8% for thigh atrophy, using table 37, page 77, and 7% for the patellofemoral dysfunction, using table 64, page 85. Dr. Prostic testified claimant's injury was the prevailing factor in his injury and symptoms. He agreed the *Guides* contain language cautioning a physician from using more than one method to provide a rating, but he believed claimant had several separate problems. The doctor stated the injury caused claimant's atrophy and the atrophy accelerated claimant's patellofemoral problem.

Dr. Prostic testified it is possible the grade III changes of the trochlea and patellofemoral joint and the grade III changes of the medial facet of the patella preexisted the injury. Dr. Prostic did not impose any permanent work restrictions.

Dr. Prostic testified based upon claimant's age, weight and work injury, it is "more likely than not that he will eventually require total knee replacement arthroplasty."[8] He also noted, "[I]n the long run, it's expected that he will have progressive increase to the point of needing surgery."[9] Part of his rationale was that claimant had significant loss of cartilage in his medial and anterior compartments and abnormal load will be placed on the remaining aspects of the medial compartments, causing accelerated degeneration of his knee. Dr. Prostic testified he did not make such conclusion in his report because he believed a total knee replacement was not needed in the near future. Dr. Prostic testified:

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[6] A squint of the patella indicates the patella is pointed more laterally than it should be and predisposes a person to recurrent subluxation. Prostic Depo. at 7.

[7] Normal range of motion is 0-135°. *Id*. at 7-8.

[8] *Id*. at 9.

[9] *Id*. at 11.

> A. The report I have in my chart is that his X-rays look good. So I hesitate to recommend a knee replacement with someone with a good-looking knee radiologically. My recommendation is that he do his best to lose weight, do his best to regain muscle tone in his thigh, and hopefully any additional surgery could be postponed for a significant number of years.
>
> Q The exercise that you have suggested is just a home exercise program?
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> A. I think the best outcome is when it's done at home.[10]

Dr. Prostic noted injections may provide claimant temporary benefit, but would provide no long-term effect.

Dr. Prostic suggested claimant ride an exercise bike 30 miles per day to diminish claimant's weight (325 pounds) as a factor predisposing degeneration of his knee. Dr. Prostic admitted a medial meniscus tear by itself would not generally lead to a recommendation for a total knee replacement and claimant's articular loss of cartilage, some of which likely predated his injury, could continue even absent the work injury. Dr. Prostic stated claimant's injury made his preexisting degeneration likely to progress or speed up and could certainly make his arthritis more symptomatic. The doctor also noted claimant should do exercise to strengthen his thigh muscle.

Following a prehearing settlement conference, the judge appointed Peter Bieri, M.D., an ear, nose and throat (ENT) doctor who is board certified by the American Academy of Disability Evaluating Physicians, to perform an independent medical examination. In the judge's order, Dr. Bieri was only asked to address claimant's impairment; he was not asked to provide an opinion regarding future medical treatment.[11] Claimant saw Dr. Bieri on September 8, 2014. Dr. Bieri's physical examination revealed no effusion, no gross instability, no significant atrophy and normal strength, but moderate patellofemoral pain and crepitance. Claimant's active range of motion was measured to be 0° extension and 120° flexion.

Pursuant to the *Guides*, Dr. Bieri assigned claimant a 2% left lower extremity impairment for the partial medial meniscectomy, using page 85, and 5% left lower extremity impairment for the residuals of patellofemoral pain and crepitance, using page 83. Dr. Bieri opined claimant had a combined 7% left lower extremity impairment. He concluded the injury was the prevailing factor in claimant's permanent impairment. Dr. Bieri noted claimant was under no active care, with the exception of over-the-counter medication as needed for pain relief.

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[10] *Id*. at 20-21.

[11] Similarly, the parties' joint letter to Dr. Bieri, contained in the administrative file, does not ask Dr. Bieri to address whether claimant will more likely than not require future medical treatment.

Dr. Prostic did not argue that Dr. Bieri should not have given a rating for patellofemoral syndome, but did not understand Dr. Bieri's 5% rating for patellofemoral pain and crepitance using page 83 of the *Guides*. Dr. Prostic noted page 85 concerns patellar subluxation or dislocation with residual instability and provides a 7% rating. Dr. Prostic further noted crepitance involves an upper extremity rating.

Claimant denied any preexisting left knee pain or popping and indicated he had never seen a doctor for his left knee prior to his accidental injury. As of March 2, 2015, claimant testified he did not feel surgery was beneficial. He still has pain when walking, going up stairs, climbing ladders or kneeling. The more he walks, the more his knee hurts and occasionally, it will pop. He can no longer stand as long as he used to and feels his left leg is not as strong as it was before the accident. He stated his left knee is tender and has decreased range of motion. Claimant stated he told Dr. Figuerres at his last appointment that his knee still popped and hurt when he walked, but Dr. Figuerres said it was normal and would eventually stop. He then mentioned to respondent that his knee was still hurting, but was told there was nothing else they could do. Since being released, claimant has not sought any additional medical treatment nor taken any medication for pain. He continues to work without restrictions.

PRINCIPLES OF LAW

K.S.A. 2012 Supp. 44-501b(b) states an employer is liable to pay compensation to an employee incurring personal injury by accident arising out of and in the course of employment. According to K.S.A. 2012 Supp. 44-501b(c), the burden of proof shall be on the claimant to establish his or her right to an award of compensation and the trier of fact shall consider the whole record.

K.S.A. 2012 Supp. 44-508 states in part:

> (d) "Accident" means an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. "Accident" shall in no case be construed to include repetitive trauma in any form.
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> . . .
>
> (f)(1) "Personal injury" and "injury" mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.

(2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.

. . .

(B) An injury by accident shall be deemed to arise out of employment only if:

(i) There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and

(ii) the accident is the prevailing factor causing the injury, medical condition, and resulting disability or impairment.

. . .

(3) (A) The words "arising out of and in the course of employment" as used in the workers compensation act shall not be construed to include:

(i) Injury which occurred as a result of the natural aging process or by the normal activities of day-to-day living;

(ii) accident or injury which arose out of a neutral risk with no particular employment or personal character;

(iii) accident or injury which arose out of a risk personal to the worker; or

(iv) accident or injury which arose either directly or indirectly from idiopathic causes.

. . .

(g) “Prevailing” as it relates to the term “factor” means the primary factor, in relation to any other factor. In determining what constitutes the “prevailing factor” in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

(h) “Burden of proof” means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act.

. . .

(u) "Functional impairment" means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of impairment, if the impairment is contained therein.

K.S.A. 2012 Supp. 44-510d states, in part:

(a) Where disability, partial in character but permanent in quality, results from the injury, the injured employee shall be entitled to the compensation provided in K.S.A. 44-510h and 44-510i, and amendments thereto. The injured employee may be entitled to payment of temporary total disability as defined in K.S.A. 44-510c, and amendments thereto, or temporary partial disability as defined in subsection (a)(1) of K.S.A. 44-510e, and amendments thereto, provided that the injured employee shall not be entitled to any other or further compensation for or during the first week following the injury unless such disability exists for three consecutive weeks, in which event compensation shall be paid for the first week. Thereafter compensation shall be paid for temporary total or temporary partial disability as provided in the following schedule, 66⅔% of the average weekly wages to be computed as provided in K.S.A. 44-511, and amendments thereto, except that in no case shall the weekly compensation be more than the maximum as provided for in K.S.A. 44-510c, and amendments thereto.

(b) If there is an award of permanent disability as a result of the injury there shall be a presumption that disability existed immediately after the injury and compensation is to be paid for not to exceed the number of weeks allowed in the following schedule:

. . .

(16) For the loss of a leg, 200 weeks.

. . .

(23) Loss of or loss of use of a scheduled member shall be based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.

K.S.A. 2012 Supp. 44-510h states:

(a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation . . . as may be reasonably necessary to cure and relieve the employee from the effects of the injury.

. . .

> (e) It is presumed that the employer's obligation to provide the services of a health care provider . . . shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. The term "medical treatment" as used in this subsection (e) means only that treatment provided or prescribed by a licensed health care provider and shall not include home exercise programs or over-the-counter medications.

Board review of a judge's order is de novo on the record.[12] The determination of the existence, extent and duration of the injured worker's incapacity is left to the trier of fact.[13] The trier of fact must decide the nature and extent of injury and which testimony is more accurate and/or credible and may adjust the medical testimony (without being bound by the medical evidence) with the testimony of claimant and any other testimony relevant to the issue of disability.[14]

ANALYSIS

1. Claimant has an 8.5% impairment to his left leg as a result of his injury by accident.

The Board has considered the totality of the evidence and concludes claimant sustained an 8.5% impairment to his left leg as a result of his injury by accident.

Dr. Figuerres' rating was solely based on claimant's knee range of motion. Dr. Figuerres should have used a goniometer to measure claimant's knee range of motion, but he did not do so.[15] "Eyeballing" range of motion is not enough.[16] Additionally, while it may be Dr. Figuerres' preference not to rate a patient for having surgery, the *Guides* allow a 2% rating for claimant's partial meniscectomy.

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[12] See *Helms v. Pendergast*, 21 Kan. App. 2d 303, 899 P.2d 501 (1995).

[13] *Boyd v. Yellow Freight Systems, Inc.*, 214 Kan. 797, 522 P.2d 395 (1974).

[14] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991), *superseded on other grounds by statute.*

[15] See *Guides* at 13. ("For evaluating ranges of motion of the upper and lower extremities, small and large goniometers are needed.").

[16] Of note, no physician recorded enough range of motion deficit to qualify claimant for impairment based thereon. However, Dr. Figuerres simply did not follow directives in the *Guides*.

The *Guides* reluctantly permit a rating based on more than one approach.[17] The bulk of Dr. Prostic's rating is for conditions other doctors did not rate – thigh atrophy and patellar instability. Dr. Figuerres did not measure claimant's thighs to check for atrophy, which is another reason to discount his opinion. However, Dr. Bieri specifically looked for and did not identify or rate any significant thigh atrophy. Dr. Bieri did not find any gross knee instability. Even though the majority of Dr. Prostic's rating consists of deficits Dr. Bieri did not identify, it may make sense for a board certified orthopedic surgeon to perhaps possess a better grasp of evaluating a knee than an ENT doctor.

We would prefer to give credence to the court-ordered doctor's rating, but Dr. Bieri's opinion is not optimal. Table 62 of the *Guides* concerns arthritis impairments based on roentgenographically determined cartilage intervals. "Roentgenograms" are radiographs or x-rays. A footnote to Table 62 of the *Guides* allows a 5% lower extremity impairment for a patient with "a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on roentgenograms . . . ."[18] Dr. Bieri did not review any radiographs and the footnote only applies to a patient *without* joint space narrowing. It would be difficult for Dr. Bieri to measure claimant's joint space narrowing without an x-ray or visual inspection of the inside of claimant's knee. Dr. Figuerres surgically viewed the interior of claimant's knee and observed grade III changes of the patellofemoral joint. We interpret his testimony as a decrease in cartilage thickness of at least 50%, but not as bad as grade IV, which would be "bone-on-bone." Arguably, claimant's knee impairment under Table 62 may be worse than 5%, but no other doctor rated claimant for arthritis. Further, there is no proof claimant's degenerative arthritis is compensable under the current version of the Act. In fact, Dr. Figuerres indicated claimant's arthritic changes were preexisting and not caused by his work injury.

We conclude claimant's impairment is 8.5% to the left leg, as based between a 2% rating for a partial meniscectomy and Dr. Prostic's 15% rating.

2. Claimant is entitled to seek future medical treatment.

The evidence regarding future medical is conflicting. The court-ordered doctor was not asked to address claimant's potential need for future medical, so his lack of an opinion is not helpful to resolving this issue.

Dr. Figuerres testified claimant will not need a total knee replacement due to his work injury. He also testified it would be "tough" to say claimant would need a total knee replacement in 20-30 years based on his operated meniscus, and doing so would require him to surmise or speculate.

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[17] See *Guides* at 84.

[18] *Guides* at 83.

The concept of medical treatment involves many potential modalities. "Treatment" is a "broad term covering all the steps taken to effect a cure of an injury or disease; including examination and diagnosis as well as application of remedies."[19] Future medical treatment does not include over-the-counter medicine or home exercise. Dr. Figuerres did not specifically address claimant's need for future medical treatment. He only addressed claimant's potential need for a total knee replacement. Dr. Figuerres' testimony concerning the broad topic of future medical treatment is not particularly helpful when he focused on only one possible procedure.

Dr. Prostic testified claimant will need a total knee replacement based on a variety of factors, including his injury, surgical removal of cartilage, age and weight. This testimony is sufficient to show claimant will likely need additional medical treatment. The fact claimant may never need a total knee replacement does not detract from Dr. Prostic's testimony that claimant more likely than not will need future surgery. Claimant need not currently prove his accident is the prevailing factor for a medical condition which has yet to occur. That is a bridge that claimant may attempt to cross in the future.[20] Currently, claimant need only prove, more likely than not, that he will need medical treatment in the future. Of course, whether respondent is legally responsible for providing such surgery will depend on potential future events, facts and litigation.

Whether claimant needs a total knee replacement is putting the cart in front of the horse. No doctor says claimant currently needs a total knee replacement. Dr. Prostic's testimony is sufficient to show claimant will likely require future medical treatment.

CONCLUSIONS

Claimant sustained an 8.5% impairment of function to his left leg as a result of his injury by accident. Claimant is entitled to seek future medical treatment upon proper application.

AWARD

WHEREFORE, the Board modifies the June 22, 2015 Award as noted in the "Conclusions" section.

IT IS SO ORDERED.

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[19] *Hedrick v. U.S.D. No. 259*, 23 Kan. App. 2d 783, 785, 935 P.2d 1083 (1997).

[20] K.S.A. 2012 Supp. 44-510k(a)(2) requires that any subsequent award of medical treatment involve a finding that the injury which was the subject of the underlying award is the prevailing factor in the need for said further medical care.

Dated this _____ day of December, 2015.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

DISSENT

The undersigned agrees with the judge and concludes claimant did not meet his burden of proving more likely than not that additional medical treatment "will be necessary" after he reached maximum medical improvement. Whether claimant will need future medical treatment of any sort, including a total knee replacement, is speculative.

_____
BOARD MEMBER

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Honorable Rebecca A. Sanders